SAN FRANCISCO OFFICE
STATE BUILDING ANNEX
395 OYSTER PT. BLVD

MAILING ADDRESS:
OFFICE OF BENEFIT DETERMINATION

P. O. BOX 603
SAN FRANCISCO, CA 94101-0603

LOS ANGELES OFFICE
LOS ANGELES STATE OFFICE BUILDING
107 SOUTH BROADWAY
LOS ANGELES, CA 90012-4578

STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

REQUEST FOR INFORMAL RATING
By Insurance Carrier or Self-Insurer

To: Office of Benefit Determination
Division of Workers' Compensation

Date:

From:

Carrier's Claim No.:

Address:

Employer:

Employee:

Address:

Social Security Number:

Date of Injury:

Month, Day and Year of Birth:

Age at Injury:

Occupation: (IF OCCUPATION IS NOT CLEARLY DEFINED, ATTACH JOB DESCRIPTION.)

Wage or Earning Capacity: $ Per week / month:
(Including additional advantages) (IF LESS THAN MAXIMUM FOR TEMPORARY OR PERMANENT, ATTACH COMPLETE AND DETAILED STATEMENT OF EARNING CAPACITY.)

Compensation Rate:
For temporary: $
For permanent: $

Last date for which temporary compensation was paid: _____ (IF DIFFERENT FROM DOCTOR'S RELEASE DATE OR DATE SHOWN ON DIA FORM 200, PLEASE EXPLAIN)

If rehabilitation under L.C. 139.5 is involved:

(a) Is employee presently receiving rehabilitation benefits, including vocational rehabilitation temporary disability?_____

(b) If vocational rehabilitation services are concluded, last date for which temporary disability was paid was _____.

We attach our complete medical file.

By _____

Telephone No. ( ) _____